STRATEGIC GOAL 3

Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

VA will work to ensure that veterans have dignity in their lives, especially in time of need, through the provision of health care, pension programs, and life insurance; and the Nation will memorialize them in death for the sacrifices they have made for their country.

This table identifies estimates of the total resources devoted to this strategic goal and its associated objectives:

Resources by Goal and Objective	FY 2002 Obligations	% of Total VA Resources
Total VA Resources	$58,899	
Strategic Goal		
Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.	$16,776	28.5%
Objective		
Provide high quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.	$11,066	18.8%
Process pension claims in a timely and accurate manner to provide eligible veterans and their survivors a level of income that raises their standard of living and sense of dignity.	$3,405	5.8%
Maintain a high level of service to insurance policy holders and their beneficiaries to enhance the financial security of veterans' families.	$2,006	3.4%
Ensure that the burial needs of veterans and eligible family members are met.	$214	0.4%
Provide veterans and their families with timely and accurate symbolic expressions of remembrance.	$85	0.1%

Several key performance measures enable us to determine progress toward achieving this strategic goal:

- Chronic Disease Care Index II
- Prevention Index II
- Patient satisfaction with health care service
- Patient safety – bar code medication administration
- Balanced Scorecard: Quality-Access-Satisfaction-Cost
- Waiting times for appointments and treatments
- Timeliness of pension claims processing
- Average days to process insurance disbursements
- Percent of veterans served by a burial option
- Quality of service provided by national cemeteries
- Timeliness of marking graves

Objectives

Provide high quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.

Performance Goals

Perform at 78 percent on the Chronic Disease Care Index II.

Definition: *The CDCI II measures how well VA follows nationally recognized clinical guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, congestive heart failure, major depressive disorder, and tobacco use cessation. Within the Index, each indicator's numerator is the number of patients in the random sample who actually received the intervention they were eligible to receive. The denominator for the calculation is a random sample of the number of patients who are eligible for the intervention. The overall Chronic Disease Index score is comprised of the percent compliance for each indicator summed and divided by the number of individual indicators.*

Perform at 80 percent on the Prevention Index II.

Definition: *This index charts the outcomes of nine medical interventions that measure how well VA follows national primary-prevention and early-detection recommendations for several diseases or health factors that significantly determine health outcomes: immunizations for both pneumococcal pneumonia and influenza; screening for tobacco and problem alcohol use; cancer screening for colorectal, breast and cervical cancer; screening for hyperlipidemia; and counseling regarding the risks and benefits of prostate cancer screening. Within the Index, each indicator's numerator is the number of patients in the random sample who actually received the intervention they were eligible to receive. The denominator for the calculation is a random sample of the number of patients who are eligible for the intervention.*

Increase to 66 percent the proportion of inpatients and maintain at 67 percent the proportion of outpatients rating VA health care service as "very good" or "excellent."

Definition: *The survey consists of a sample of inpatients and a sample of outpatients who respond to a question on the semi-annual inpatient and the quarterly outpatient surveys. The numerator consists of a sample of inpatients and a sample of outpatients who rate their overall quality of care as very good or excellent. The denominator is the total number of inpatients or outpatients in the sample who responded to the survey.*

Increase to 100 percent the number of facilities that have a Bar Code Medication Administration (BCMA) contingency plan and conduct test of plans annually.

Definition: *BCMA is a computer program that electronically documents medications at the bedside or other points of care using bar code technology. If the computer system were to fail, it would present a single-point vulnerability for medication administration, and facilities need to have in place an adequate contingency plan for loss of BCMA. Facilities must have a back-up plan to safely continue medication administration in the event of an internal disaster. This measure addresses a system issue affecting all medical centers, and ensures a smooth transition to the contingency medication administration process under various system-failure scenarios. The numerator is the number of VA medical facilities that have developed and tested their plan, and the denominator is the number of facilities that administer medication using bar code technology.*

Increase the Balanced Scorecard: Quality-Access-Satisfaction-Cost to 101 percent.

Definition: *The VHA Balanced Scorecard provides a framework for translating VHA's strategic objectives into performance measurements driven by key performance measures. The sources of data for these performance measures are the same as those identified for the specific components comprising the measures – Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient satisfaction; waiting times for primary care and specialty clinics; and wait times to see a provider. The cost element is obligations per unique patient in constant dollars. All four components in the scorecard are of equal weight (each component is 25 percent of the total). Progress toward the goal is identified as well as areas where the goal is exceeded.*

Increase the percent of primary care appointments scheduled within 30 days of the desired date to 88 percent.

Increase the percent of specialist appointments scheduled within 30 days of the desired date to 85 percent.

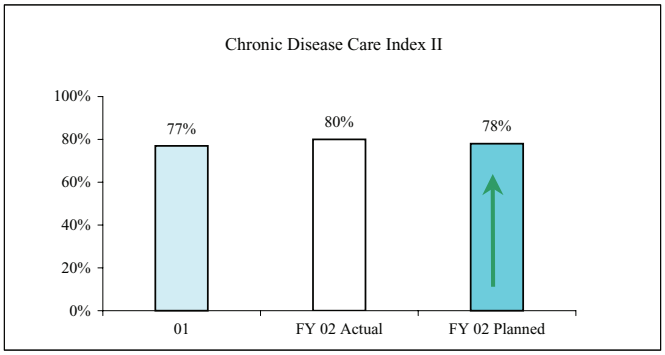
Definition: *Waiting time is the number of days between the date the patient would like the primary care clinic appointment or specialty clinic appointment and the date that appointment is actually scheduled. This measure currently includes return visit scheduling only and does not portray the wait experience of new enrollees and new patients.*

Increase the percent of patients who report being seen within 20 minutes of their scheduled appointments at VA health care facilities to 70 percent.

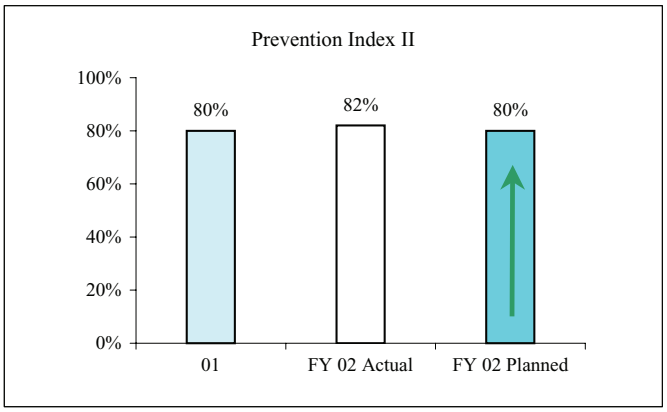
Definition: *Patients seen in an outpatient clinic are asked in a survey, "How long after the time when your appointment was scheduled to begin did you wait to be seen?" This is done as part of the quarterly outpatient satisfaction survey and responses are tabulated to establish the percent of patients who reported waits of 20 minutes or less.*

VA's quality program ensures system-wide delivery of health care based on the best scientific evidence for clinical practice and is the benchmark in quality for numerous areas when compared with other health care systems. A recent report from the Institute of Medicine, *Leadership by Example*, praised VA's use of performance measures to improve quality in clinical disciplines.

The measures discussed below address our commitment to provide quality, accessible, timely and safe health care through our continuous improvement process.



A new methodology was adopted for FY 2001. Therefore, prior year comparisons are not available.



A new methodology was adopted for FY 2001. Therefore, prior year comparisons are not available.

Quality

These performance goals address VA's priority of providing high-quality medical care that meets or exceeds community standards. VHA ensures that its policies are carried out through a strategic management framework that relies on performance goals and a performance measurement program that monitors progress and promotes accountability. The management framework is comprised of six domains of quality: quality of care, patient satisfaction, functional status, access, cost efficiency, and building healthy communities.

Chronic Disease Care Index II and Prevention Index II

VA surpassed the goal for the Chronic Disease Care Index II by achieving 80 percent and exceeded the goal for the Prevention Index II by achieving 82 percent by continuing to emphasize the importance of the many clinical practices that comprise these aggregated index measures. Use of these clinical practice guidelines is directly linked to improved health outcomes. Emphasis on these important areas of quality will continue to be a cornerstone of clinical performance measurement for the Department. The purpose of emphasizing effective chronic disease management is to improve the health of veterans while reducing the use of services and enhancing efficiency. Since a large percentage of veterans seek care for one or more chronic diseases, improved management of chronic disease results in reduced inpatient costs, admissions, and lengths of stay.

The Chronic Disease Care Index II follows nationally recognized guidelines for the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, congestive heart failure, major depressive disorder, and tobacco use cessation. Twenty-one medical interventions are used as assessments. The index provides a comprehensive representation of chronic care management.

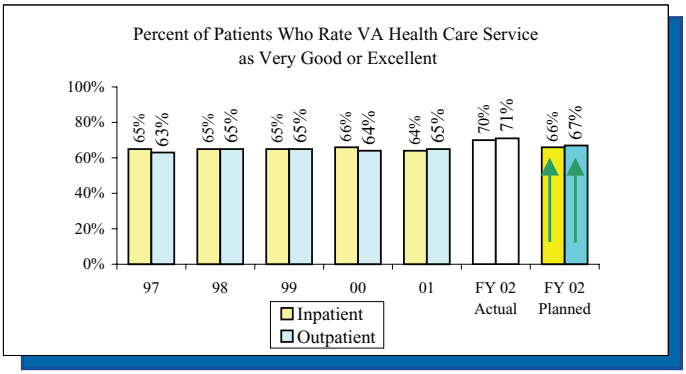
VA has designed the Prevention Index II to include several indicators that allow a comparison of VA and private health care outcomes. In 16 of the 18 indicators that have data comparable to managed care organizations and population-based surveys,[1] VA is the benchmark exceeding the best competitor's performance. In many cases, VA has moved from the comparative measure to require more stringent indicators of care. For example, evidence shows patients who have had heart

attacks have less risk of additional heart attacks and death if they take beta-blockers. The Health Plan Employer Data Information Set (HEDIS) comparative indicator measures whether patients who have had a heart attack have a prescription for a beta-blocker upon discharge from the hospital. VA's performance on this measure has been in the 90 percent range for several years. The most recent results of the 18 comparable indicators are as follows:

MEASURE	VA AVERAGE	BEST COMPETITOR
Advise smokers to quit at least once in past year	93%	66% NCQA
Beta-blocker on discharge after heart attack	94%	92% MMCP
Breast cancer screening	80%	75% MMCP
Cervical cancer screening	89%	78% NCQA
Cholesterol screening in all patients	88%	69% BRFSS 2
Cholesterol measured after heart attack[3]	89%	76% NCQA
Cholesterol less than 130 after heart attack[4]	71%	57% NCQA
Colorectal cancer screening	60%	44% BRFSS 5
Diabetes: HgbA1c done past year	93%	84% MMCP
Diabetes: Poor control[6] (lower number is better)	20%	43% NCQA
Diabetes: Cholesterol (LDLC) measured	91%	84% MMCP
Diabetes: Cholesterol (LDLC) Controlled (<130)	68%	46% NCQA
Diabetes: Eye Exam	66%	68% MMCP
Diabetes: Renal Exam	72%	46% NCQA
Hypertension: BP $\leq$ 140/90 most recent visit[7]	57%	52% NCQA
Immunizations: influenza, patients 65 and older[8]	73%	75% MMCP
Immunizations: pneumococcal, patients 65 and older[9]	79%	46% NHIS
Mental Health follow-up within 30 days of inpatient discharge	84%	73% NCQA

[1] VA data are compared with National Committee for Quality Assurance (NCQA) (The State of Managed Care Quality, Industry Trends and Analysis, 2001: patients are all ages in private managed care programs); Medicare Managed Care Plans (MMCP), CDC sponsored surveys (CDC, Behavioral Risk Factor Surveillance System (BRFSS) survey from National Center for Chronic Disease Prevention & Health Promotion: telephone survey of states, sample intended to be representative of the population of each state with varying numbers of states involved in each of the measures); HHS, National Center Health Statistics (NCHS) reports and Healthy People 2010 goals. When non-VA data are not available, VA compares its current performance to its past trend data.
[2] BRFSS scores are median; VHA scores are average
[3] VA ongoing annually; NCQA 1st year after attack
[4] VA ongoing annually; NCQA 1st year after attack
[5] BRFSS scores are median; VHA scores are average
[6] DM poor control defined by VHA $\geq$ 9.5; NCQA > 9.5 values for most recent HgbA1c
[7] VA includes all ages; NCQA includes ages 46-85 years
[8] This VHA number matches NCQA methodology to exclude high-risk patients under age 65. VHA Network Director's performance measure includes high risk patients and patients 65 or older (68 percent).
[9] VHA includes high-risk patients less than age 65 in this number; comparative data indicate even though at high risk, patients under 65 have a lower rate of having the immunization.

Percent of patients rating VA health care service as very good or excellent (Inpatient/Outpatient)



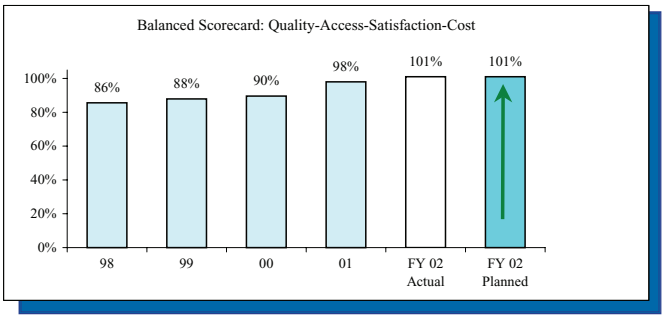
Results of the 2002 Survey of Healthcare Experience of Patients (SHEP) show substantial improvement in the overall quality ratings for both inpatient and outpatient care. Although these results are impressive, the very size of the improvements described suggests that part of the increase in satisfaction may be due to changes from the old satisfaction survey formats to the expanded content and altered formats of the SHEP. For inpatients, preliminary analyses suggest a national 6-point increase to 70 percent. Significant increases above the 2001 average of 64 percent were observed in 19 out of 21 Veterans Integrated Service Networks (VISNs). Eleven VISNs met or exceeded the "exceptional" goal for the year, which was 70 percent. In the outpatient setting, a 6-point gain to 71 percent in satisfaction was observed nationally. Fourteen of 21 VISNs met or exceeded the "exceptional" goal (72 percent), while another 3 VISNs met or exceeded the "fully satisfactory" goal (70 percent). Further analyses and the increased availability of SHEP data owing to more frequent sampling and roll-up should allow VA to better describe the drivers of patient satisfaction in future reports.

Bar Code Medication Administration (BCMA) contingency plan and conduct test of plans annually

VA achieved the planned target level of 100 percent of VHA facilities with contingency plans for BCMA. Contingency plans are based on requirements set by VHA's BCMA Committee. In doing an assessment of vulnerabilities, VHA determined that the lack of a contingency plan for BCMA was a significant patient safety vulnerability that required immediate resolution. The vision is to continue to identify patient safety vulnerabilities with system-wide implications for immediate resolution.

Balanced Scorecard: Quality-Access-Satisfaction-Cost

VHA achieved its goal of 101 percent in 2002 for the balanced scorecard, which provides a framework for translating strategic objectives into performance measurements driven by key performance measures. This measure establishes a percent of goal relationship for cost in the same manner as done for desired outcomes of quality, access, and satisfaction. All four components in the scorecard are of equal weight (each component is 25 percent of the total). Progress toward the goal is identified as well as areas where the goal is exceeded. Since the overall quality, access and satisfaction numbers increased at the same time more veterans were being seen but without an equal increase in funding, the greater than 100 percent goal indicates more efficiency for better or same level of care.



Access

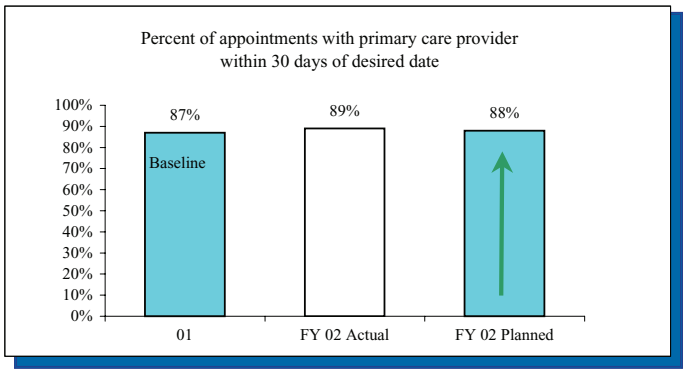
Access and waiting times are key to improving patients' perceptions of the quality of VA care and their overall satisfaction. VHA is addressing the clinic wait time issue on multiple fronts; a working group is developing mechanisms to decrease the

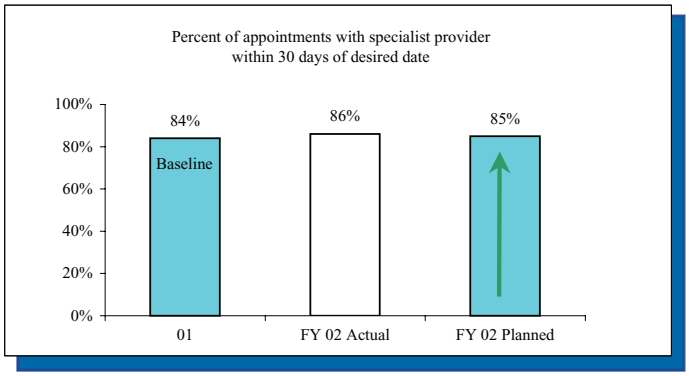
number of veterans on waiting lists. Guidance will be provided to assist facilities in prioritizing veterans by level of service connection and medical need.

Current VHA measures for waiting times measures reflect only the experience of veterans already "in the system" and do not accurately portray the wait experience of new enrollees and new patients. New patients in primary care are those who have not been seen at that facility for the last 24 months. New patients in specialty care are those who have not been seen in that specialty clinic in the last 24 months. Currently, VHA is evaluating and developing a standard entry process for new enrollees that will allow for tracking patients from time of enrollment to first appointment. In 2002, VHA conducted a new enrollees survey to assess the current veteran experience with waiting times after enrollment. This survey has provided further information to assist in improving the process for entry into the VA medical care system. In addition, other waiting time measures have been developed to look at average wait time for new patients seeking clinic appointments and average days to next available appointment for both primary care and specialty appointments. The quarterly Survey of Healthcare Experience of Patients (SHEP) provides patient satisfaction data on how long patients must wait once they arrive to be seen by a practitioner (20 minutes or less).

Percent of appointments with primary care provider within 30 days

Eighty-nine percent of primary care appointments were scheduled within 30 days of the desired date in 2002 compared to our goal of 88 percent. This was an improvement over the 2001 actual of 87 percent. We did this by continuing to work on our Advanced Clinic Access initiative that focuses on key changes in office practice efficiencies. We also continued to work on modifying our scheduling practices, hiring and retraining/ reassigning clinical staff to outpatient primary care, and renovating existing facility-based clinic space to provide clinicians with two examination rooms each, thus improving patient flow. Internally the additional measures outlined above evaluate sub-groups within these clinic wait times -- "next available" appointment and "new" patient "next available" appointment allows for further analysis to determine areas where action can be taken to improve the overall waiting times.





Percent of appointments with a specialist within 30 days

Eighty-six percent of specialty care appointments were scheduled within 30 days of the desired date in 2002 compared to our goal of 85 percent. This was an improvement over the 2001 actual of 84 percent. We did this by continuing to implement and reap the benefits from modified appointment scheduling and pre-appointment patient reminders as ascribed by the Institute for Healthcare Improvement. Other process-related improvements included dual credentialing for specialists in primary care practice (especially useful for cardiac, diabetic, high blood pressure, cancer, and other patients with an overriding condition that needed to be monitored by a specialist) and retraining primary care clinicians to treat lower level, specific conditions. This combined approach, along with

augmented and redirected specialty care and other resources, improved spatial configurations via renovation. Updated equipment will continue to help us achieve greater efficiencies without compromising access to, or quality of, specialty care.

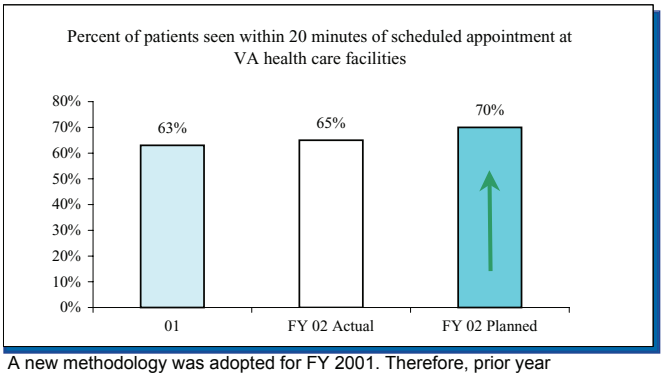
Using a weighted averaging methodology, the average number of days to obtain an appointment in the specialty clinics listed below was 36.5 days in 2002. The waiting times for individual clinics in 2002 were:

Audiology	32.3 days
Cardiology	33.2 days
Eye Care	48.0 days
Orthopedics	32.3 days
Urology	35.7 days

Percent of patients who report being seen within 20 minutes of scheduled appointment

VHA achieved an overall national average of 65 percent of patients who reported being seen within 20 minutes of their scheduled appointment. Although this is an improvement over the 2001 achievement of 63 percent (recalculated to reflect the new methodology discussed below), we did not reach our goal of 70 percent. A VISN-specific analysis of all 21 VISNs indicates that 8 VISNs met or exceeded the target level of 70 percent. This target shortfall is a reflection of the overall increased volume of patients in VHA as well as facility actions to make appointments for veterans on a wait list.

VHA has experienced a large growth in enrolled veterans over past years. This growth has stretched the capacity of the systems resulting in some veterans being placed on a waiting list for their first appointment. The impact of obtaining appointments for patients that results in over capacity has resulted in the waiting time for the provider to increase. The modest increase experienced even with the large enrollment of veterans is due to concurrent initiatives to increase efficiency and productivity while at the same time making a concerted effort to decrease the waiting lists. Initiatives such as advance access and development of an electronic process of managing wait lists have positively impacted access to care. VISNs continue to explore and implement ways to provide scheduled appointments in a timely fashion.



A new methodology was adopted for FY 2001. Therefore, prior year comparisons are not available.

Starting in 2002, a new methodology for calculating this percentage was adopted: the universe of patients surveyed was expanded to include all provider-run clinics; the number of patients sampled was made proportional to clinic size, such that larger clinics now carry greater weight in the sample; and scores are now presented as "satisfaction scores" rather than "problem rates." Although the new methodology at first lowers our overall percentage, it provides a model that is more sensitive to change than the one used previously. This increased sensitivity, along with the increase in frequency of the survey (to quarterly), will provide medical centers with a more accurate reflection of the impact of actions taken to improve patient satisfaction. This new baseline number was used to project improvement in 2002 and beyond.

Means and Strategies

Chronic Disease Care Index II and Prevention Index II

We included the components of this measure among the set of Network Director annual performance measures for 2002. These measures are rolled up nationally on a quarterly basis,

but many VISNs separately track their own performance on a monthly basis.

Percent of patients rating VA health care service as very good or excellent (Inpatient/Outpatient)

VA relies on periodic feedback from veterans, obtained through surveys, as to their level of satisfaction with clinical service and other elements of their healthcare experience and utilization. VHA's Performance Analysis Center for Excellence (PACE) conducts a national Survey of Healthcare Experiences of Patients (SHEP) that allows a better understanding of patient expectations and needs. The satisfaction elements of these surveys target those dimensions of care that veterans identified as most important to them in focus groups. Veteran satisfaction performance is externally compared to other large organizations through use of the National Research Corporation (NRC)/Picker Satisfaction question sets. Surveys are sent to substantial samples of patients who have recently received care in all provider-run (Medical Doctor, Nurse Practitioner, Physician's Assistant) clinics and inpatient settings. The satisfaction elements of the SHEP are in turn compared to comparable care settings of other large healthcare organizations to identify potential areas requiring action. VA is also participating in the Agency for Healthcare Research and Quality-led effort to develop new, standardized satisfaction question sets, which will serve as a proposed national standard.

Bar Code Medication Administration (BCMA) contingency plan and conduct test of plans annually

VHA's National Center for Patient Safety (NCPS) collected contingency plans from each VHA facility for coping with loss of the electronic medication administration procedure called the Bar Code Medication Administration (BCMA) system. The contingency plans are based on the Healthcare Failure Modes and Effects Analysis (HFMEA). NCPS assessed the adequacy of each plan to provide viable workarounds to potential BCMA system failures.

Balanced Scorecard: Quality-Access-Satisfaction-Cost

The sources of data for the balanced scorecard are the same as those identified for the specific components comprising the measures – Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient satisfaction; waiting times for primary care and specialty clinics; and wait times to see a provider. The cost element is obligations per unique patient in constant dollars. The data included in these computations have the same validity as the individual components, as outlined in each of their respective segments.

The following strategies were implemented during 2002 to improve access to and timeliness of health care:

- Trained or retrained existing transferable staff from inpatient to outpatient care.
- Implemented the Advanced Clinic Access initiative based on Institute for Healthcare Improvement methodology.
- Evaluated, and where appropriate, added mental health care to existing community-based outpatient clinics (CBOCs). Planning for mental health is now added to all new CBOC proposals.
- Increased the number of contracts for specialists to provide services to veterans.
- Continued infrastructure renovation in existing facilities to ensure that at least two exam/treatment rooms are available for each clinician providing care on a given day.
- Continued to develop transplant-sharing agreements.
- Continued to provide outpatient medication-dispensing technology in CBOCs and hospital-based clinics.

- Developed backlog reduction plans to address short- and long-term strategies in both primary and specialty care areas.
- Tracked on a bi-weekly basis the number of veterans on wait lists.
- Developed an electronic wait list to track veterans in a standardized fashion.

Major Management Challenges

In response to concerns about waiting times, VA established strategic targets for the time it takes veterans to get an appointment with a VA provider (either primary care or specialty care) and the time they spend waiting in a provider's office. As part of its strategy to reduce waiting times and meet service delivery targets, VA has entered into short-term contracts with consultants to help reduce the backlog of specialty appointments. By improving waiting times through process improvements, physical plant renovations, pharmacy refills by mail and other means, VHA will effectively improve patient satisfaction and patient perceptions of the quality of their health care.

Data Source and Validation

Chronic Disease Care Index II and Prevention Index II

Data are collected using an external contractor through VHA's External Peer Review Program. Data collection is accomplished through chart abstraction by professionals such as registered nurses or registered records administrators who use specific chart abstraction logic and standardized definitions.

Data validity is ensured through a number of processes including specific orientation and ongoing training for all abstractors, an inter-rater reliability process, software alerts that identify out-of-range data (for example, weight = 550 kg instead of 55 kg), and statistical analysis of all questions and responses to identify potential 'problem' questions (questions that have large variation in responses). New statistical methods to identify non-random variation have been developed and presented at national conferences as state-of-the-art techniques for data validation.

Percent of patients rating VA health care service as very good or excellent (Inpatient/Outpatient)

The sources of the patient satisfaction data are VHA's inpatient and ambulatory care veteran surveys. The surveys consist of a sample of inpatients and outpatients who, in response to a question on the semi-annual inpatient and the quarterly outpatient surveys, rate their overall quality of care as very good or excellent. The surveys use recognized statistically valid sampling techniques. Regular reports, semi-annual for inpatient and quarterly for outpatient, are available on VISN performance.

Bar Code Medication Administration (BCMA) contingency plan and conduct test of plans annually

VHA's NCPS collected contingency plans from each VHA facility for coping with loss of the BCMA system. The contingency plans are based on the Healthcare Failure Modes and Effects Analysis (HFMEA), and NCPS assessed the adequacy of each plan to provide viable workarounds to potential BCMA system failures.

Balanced Scorecard: Quality-Access-Satisfaction-Cost

The Balanced Scorecard is based on constant dollars per patient against quality, access and satisfaction measures. Since the overall quality, access and satisfaction numbers increased at the same time more veterans were being seen but without an equal increase in funding, the greater than 100 percent goal indicates more efficiency for the same or better level of care.

The sources of data for the balanced scorecard are the same as those identified for the specific components comprising the measures— Chronic

Disease Care Index II; Prevention Index II; inpatient and outpatient satisfaction; waiting times for primary care and specialty clinics; and wait times to see a provider. The cost element is obligations per unique patient in constant dollars.

Access

In early 2000, software was implemented to measure the average next-available clinic appointment time experienced by patients needing an appointment. The software computed the clinic appointment waiting time by calculating the number of days between the date a next-available appointment is requested and the date the appointment is made. This method of measurement is believed to be superior to previous methods because it measures the actual experience of patients rather than projecting what the experience might be, based on appointment availability. A revised version of this software was released January 31, 2001. This version supports measurement of appointment waiting times for new patients to primary care.

VA is developing new clinic wait time measures to quantify the wait times of new enrollees based on survey data to assess the experiences of new enrollees in requesting appointments. The data from the new measures, other VHA wait time measures, and the survey will provide more timely and relevant data for decision-making as it relates to the increase in number of new enrollees. VA is currently developing standardized entry processes for new enrollees. This process will assist in the automated collection of relevant wait time information at the time the veteran enrolls in the system.

The source of data for the 20-minute waiting time measure is the quarterly outpatient satisfaction survey, Survey of Healthcare Experiences of Patients (SHEP). The survey is distributed and analyzed by the Office of Quality and Performance, Performance Analysis Center for Excellence (OQP/PACE). Patients are asked, “How long after the time when your appointment was scheduled to begin did you wait to be seen?” Responses are tabulated to establish the percent of patients who reported waits of 20 minutes or less.

Objective

Process pension claims in a timely and accurate manner to provide eligible veterans and their survivors a level of income that raises their standard of living and sense of dignity.

The Department has adopted a new budget account structure that will allow us to more closely link resources with results and to understand better the full cost of our programs. One facet of this new account structure, which will be presented with our 2004 Congressional budget, is to make a clear distinction between the compensation program and the pension program. Traditionally, these two programs have been viewed together as part of the overall claims processing activity in VA. But, as we move forward with the implementation of this new budget account structure, we expect to refine our performance measures so that they are more specifically linked to the two programs separately. Refer to pages 39 – 40 for more information on the VA account restructuring initiative. Refer to page 48 for a discussion of the timeliness and accuracy of claims processing, which includes both compensation and pension claims.

VA began to centralize processing of the pension maintenance workload in January 2002. Previously performed at all 57 regional offices, these functions are being consolidated at 3 sites. Centralized processing of the pension program will allow the Department to focus more resources on the compensation claims backlog. Additional employees and resources for information technology tools will aid in meeting VA's goal of reducing the time to process rating-related claims in 2003.

Objective

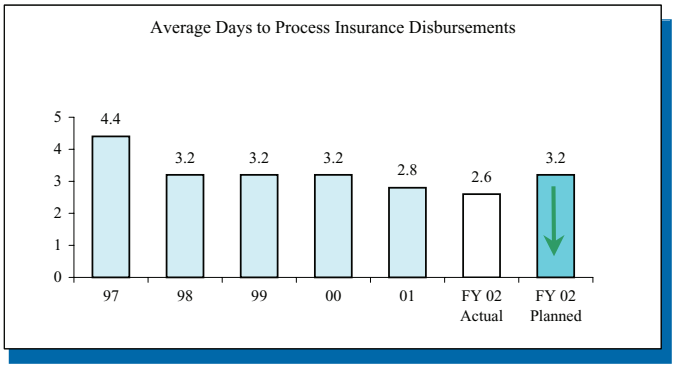
Maintain a high level of service to insurance policy holders and their beneficiaries to enhance the financial security of veterans' families.

Performance Goal

Maintain average processing time for insurance disbursements at 3.2 days.

Definition: *The weighted composite average processing days for all disbursements, including death claims and applications for policy loans and cash surrenders.*

Insurance disbursements are death claims paid to beneficiaries, as well as policy loans and cash surrenders requested by policyholders. These disbursements are considered the most important services provided by the insurance program to veterans and beneficiaries. In 2002, the program disbursed over $1.2 billion in death claims, loans, and cash surrenders. The indicator for this measure is the weighted composite average processing days for all three types of disbursements. Weighted composite average processing days means the volume processed in each category is taken into account in the calculation of the average in order to make it more representative of the group. Maintaining the high level of service to policyholders and their beneficiaries has long been a priority of the insurance program. This commitment is evidenced by the Philadelphia Insurance Center being named the recipient of the VA Secretary's 2002 Robert W. Carey Quality Award, which is presented to the organization that best exemplifies excellent service to veterans, their dependents, and beneficiaries.



The insurance program met its performance goal by maintaining an average processing time of 2.6 days for disbursements, an improvement over the 2.8 days in 2001. We have recently adjusted our strategic objective for processing of disbursements to 2.7 days and our 2003 target to 2.8 processing days.

Means and Strategies

The insurance program has undertaken various actions to improve the timeliness of disbursements including use of special post office boxes, improvements in how we process returned mail, and beginning a paperless processing system. When fully implemented, this initiative will provide online electronic storage of insurance records and online access to those records by technicians. The imaging capabilities from the initiative will reduce the time required for processing disbursements and other services. We already have a robust imaging system in place with over 4 million images available for access at every employee's desktop.

The use of special post office boxes assigns a specific post office box number to death claims, loans, and cash surrenders. Therefore, all disbursement applications are separated from the general correspondence by the Postal Service before they enter the Insurance Center. The applications are delivered directly to the operating divisions, thereby eliminating the time it would take to sort and distribute the mail.

The returned mail process allows VA insurance staff to obtain a better address for the policyholder by running a daily check against Social Security Administration (SSA) records. This results in an overnight response from SSA. In most cases, the address is obtained and updated in the insurance record without human intervention. The impact of this process has greatly reduced the processing time of returned mail and the amount of backlogged returned mail items. In addition, we use the WestlawPro public records locator database as an alternate resource for address information on veterans as well as beneficiaries for whom we were unable to obtain an SSA match. This service has proved extremely valuable in promptly locating individuals we had been unable to locate in the past.

We accelerated the schedule of the mass retirement of insurance folders and completed the project 2 years ahead of the original schedule. This allowed for space in the Philadelphia RO for the new Pension Maintenance Center. Even though we do not yet have the full imaging capabilities completed, we are using a hybrid system for disbursements consisting of imaged documents associated with temporary insurance folders. This temporary system actually provides faster disbursement processing than we expected. When we move away from the hybrid system to the full paperless processing system, we will experience clerical and payroll savings.

The Paperless Office pilot workflow was instituted in July 2002 with 1 percent of insurance death claims. This workflow automatically routes work to appropriate staff, thus decreasing death claims processing time. As of October 2002, our workflow pilot has been expanded to 8 percent of insurance claims work. Only minor programming changes are needed to accept new digits in the workflow environment.

Data Source and Validation

Processing time begins when the veteran's application or beneficiary's fully completed claim is received and ends when the internal controls staff approves the disbursement. Average processing days are a weighted composite for all three types of disbursements, based on the number of end products and timeliness for each category. The average processing days for death claims is multiplied by the number of death claims processed. The same calculation is done for loans and cash surrenders. The sum of these calculations is divided by the sum of death claims, loans and cash surrenders processed to arrive at the weighted average processing days for disbursements. Data on processing time are collected and stored through the statistical quality control (SQC) program and the Distribution of Operational Resources (DOOR) system. The Insurance Service is charged with periodically evaluating the SQC program to determine if it is being properly implemented. The composite weighted average processing days measure is calculated by the Insurance Service and is subject to periodic reviews. Timeliness information is considered to be valid for management of operations.

Objective

Ensure that the burial needs of veterans and eligible family members are met.

Performance Goals

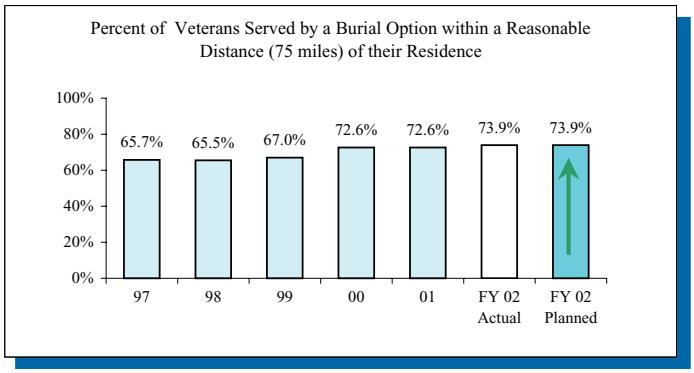
Increase the percent of veterans served by a burial option in a national or state veterans cemetery within a reasonable distance (75 miles) of their residence to 73.9 percent by the end of 2002.

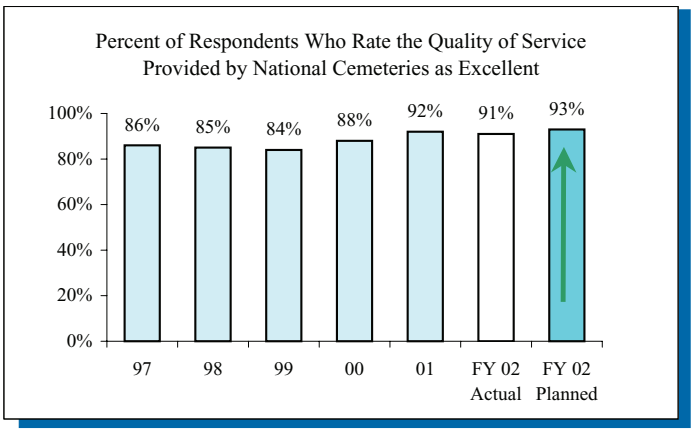
Definition: *The measure is the number of veterans served by a burial option divided by the total number of veterans, expressed as a percentage. A burial option is defined as a first family member interment option (whether for casketed remains or cremated remains, either in-ground or in columbaria) in a national or state veterans cemetery that is available within 75 miles of the veteran's place of residence.*

Increase the percent of respondents who rate the quality of service provided by the national cemeteries as excellent to 93 percent in 2002.

Definition: *The measure is the number of survey respondents who agree or strongly agree that the quality of service received from national cemetery staff is excellent, divided by the total number of survey respondents, expressed as a percentage.*

VA met its goal to increase the percent of veterans served by a burial option in a national or state veterans cemetery within a reasonable distance (75 miles) of their residence to 73.9 percent by the end of 2002. However, the goal to increase the percent of respondents who rate the quality of service provided by the national cemeteries as excellent to 93 percent was not met. Satisfaction with the quality of service provided by national cemeteries did remain at a high level in 2002: 91 percent of family member and funeral director respondents agreed or strongly agreed that the service received from national cemetery staff was excellent. Cemetery service goals are set in keeping with the high expectations of all who visit. The National Cemetery Administration (NCA) is reviewing information provided by survey respondents to identify opportunities for improvement.





VA provides interment of veterans and eligible family members upon demand. From 1998 to 2002, annual interments increased 16 percent, from 76,718 to 89,329. With the aging of World War II and Korean Conflict-era veterans, the number of deaths

is increasing each year. Based on the 1990 census, the annual number of veteran deaths is expected to peak at 684,000 in 2006 before beginning a gradual decline. This progressive increase in veteran deaths and the establishment of new national cemeteries result in a corresponding increase in the number of interments in national cemeteries.

As the annual number of interments and total gravesites used increases, cemeteries deplete their inventory of space and are no longer able to accept full-casketed or cremated remains of first family members. As a result, veterans may lose access to some of VA's burial options. At the end of 2002, only 61 of the 120 existing national cemeteries contained available, unassigned gravesites for the burial of both casketed and cremated remains; 26 accepted only cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member; and 33 performed only interments of family members in the same gravesite as a previously deceased family member.

Means and Strategies

Percent Served by a Burial Option

In 2002, to meet the burial needs of veterans, we continued planning for the development of new national cemeteries, completed construction projects to make additional gravesites or columbaria available for burials, and acquired land to continue burial options at existing national cemeteries.

VA continued to make progress in the development of new national cemeteries to serve veterans in the areas of Atlanta, Georgia; Detroit, Michigan; South Florida; Oklahoma City, Oklahoma; Pittsburgh, Pennsylvania; and Sacramento, California. These six locations were identified in a May 2000 report to Congress as the areas most in need of a new national cemetery, based on demographic studies. When open, these 6 cemeteries will provide a burial option within 75 miles of the residence of over 2 million veterans who are not currently served.

In fall 2001, operations began at Fort Sill National Cemetery, near Oklahoma City. Action is now underway to develop a new national cemetery near Atlanta, Georgia. In 2002, VA acquired property for establishing new national cemeteries to serve veterans in South Florida and the Detroit area. We are currently in the process of acquiring land for establishing new national cemeteries in the areas of Pittsburgh and Sacramento.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent demographic study to identify those areas of the country where veterans will not have reasonable access to a burial option in a national or state veterans cemetery and the number of additional cemeteries required to meet veterans' burial needs through 2020. Volume 1: Future Burial Needs, published in May 2002, identified those areas having the greatest need for burial space for veterans. The report will serve as a valuable planning tool for decisions regarding the establishment of new national cemeteries.

VA monitors gravesite usage and projects gravesite depletion dates at open national cemeteries that have land for future development. As those cemeteries approach their gravesite depletion dates, we ensure that construction to make additional gravesites or columbaria available for burials is completed. In 2002, VA completed construction projects to extend burial operations at nine national cemeteries. For example, a construction project at Santa Fe National Cemetery included site preparation and placement of 7,000 pre-placed burial crypts. At Florida National Cemetery, VA completed a construction project to develop 16,000 columbaria niches in a park-like setting of courtyards with multiple height walls and landscaping. At Fort McPherson National Cemetery in Nebraska, new construction included the development of over 2,700 gravesites, a new committal service shelter, and a new public information building.

Appropriate land acquisition is a key component to providing continued accessibility to burial options. In 2002, VA acquired land to continue operations at Natchez National Cemetery in Mississippi. We will continue to identify national cemeteries that

are expected to close because of depletion of grave space, and determine the feasibility of extending the service life of those cemeteries by acquiring adjacent or contiguous land or by constructing columbaria. These actions, which depend on such factors as the availability of suitable land and the cost of construction, are not possible in every case. Efforts to acquire additional land are currently underway at 10 national cemeteries.

Quality of Service Provided by National Cemeteries

The Department's goal is to make sure that the Nation's veterans and their families are satisfied with the quality of service provided by national cemeteries. VA strives to provide high quality, courteous, and responsive service in all of its contacts with veterans and their families.

To further enhance access to information and improve service to veterans and their families, NCA installs kiosk information centers at national and state veterans cemeteries to assist visitors in finding the exact gravesite locations of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about NCA. By the end of 2002, VA had installed 42 kiosks at national and state veterans cemeteries.

In order to accommodate and better serve its customers, VA has designated Jefferson Barracks National Cemetery as the primary cemetery to provide weekend scheduling for interments in national cemeteries for a specific time in the ensuing week.

Veterans and their families have indicated that they need to know the interment schedule as soon as possible in order to finalize necessary arrangements. To meet these expectations, VA strives to schedule committal services at national cemeteries within 2 hours of the request. In the 2002 Survey of Satisfaction with National Cemeteries, 73 percent of funeral directors responded that national cemeteries confirmed scheduling of the committal service within 2 hours.

Since the beginning of Operation Enduring Freedom, three active duty servicemembers who died in Afghanistan have been buried in national cemeteries. Sergeant First Class Nathan Ross Chapman, a member of the U.S. Army Special Forces and the first casualty of the war in Afghanistan, was interred at Tahoma National Cemetery. More than 500 people attended the committal service with military funeral honors, including senior military officers, several active and retired Special Forces members, and members of veterans support groups. U.S. Army Specialist Marc A. Anderson, killed during Operation Anaconda in eastern Afghanistan, was interred at Florida National Cemetery. Sergeant First Class Daniel A. Romero, killed near Kandahar, was interred at Fort Logan National Cemetery. The service, attended by more than 500 people, included two yovers by the Colorado National Guard.

The staff of the Eagle Point National Cemetery interred U.S. Army Sergeant First Class Eugene F. Christiansen, who had been missing in action in Vietnam since February 6, 1969. He was last seen aboard a military aircraft on a re-supply mission when radio contact with the aircraft was lost. His remains were identified by the Central Identification Laboratory in Hawaii using DNA technology.

Sergeant First Class Clarence B. Craft, U.S. Army, a World War II Medal of Honor Recipient, was interred at Fayetteville National Cemetery. SFC Craft, the "Hero of Hen Hill" on the island of Okinawa, single-handedly broke the Japanese Naha-Shuri-Yanaburu line, which had held his stalled unit for 12 days. President Harry Truman presented SFC Craft with the Medal of Honor on October 12, 1945. After retirement, Mr. Craft continued his service to our Nation by working with the VAMC Fayetteville and the Fayetteville National Cemetery as a volunteer, aiding his fellow veterans.

To ascertain how customers and stakeholders perceive the quality of service provided by national

cemeteries, VA seeks feedback through annual surveys and focus groups. This information is used to determine expectations for service delivery as well as specific improvement opportunities and training needs. Since 2001, an annual nationwide mail survey, Survey of Satisfaction with National Cemeteries, has been NCA's primary source of customer satisfaction data. The survey provides statistically valid performance information at the national and Memorial Service Network (MSN) levels and at the cemetery level for cemeteries having at least 400 interments per year. The information gathered is used in NCA's strategic planning process to develop additional strategies for improving service.

Crosscutting Activities

Percent Served by a Burial Option

To complement our system of national cemeteries, VA administers the State Cemetery Grants Program (SCGP), which provides states grants of up to 100 percent of the cost of establishing, expanding, or improving veterans' cemeteries that are owned and operated by the states.

To date, a total of 49 operating state veterans cemeteries have been established, expanded, or improved through the SCGP. In 2002, state veterans cemeteries performed over 17,000 interments, and new grants were obligated to establish or expand state veterans cemeteries in 11 states.

Two new state veterans cemeteries were opened at Grand Junction, Colorado, and Milledgeville, Georgia, in 2002. These two cemeteries provide a burial option within 75 miles of the residence of over 132,000 veterans and their families not previously served.

Following an interment in one of the state veterans cemeteries, one family wrote, "Not only were we proud of our father, you made us proud to be an American."

Quality of Service Provided by National Cemeteries

VA continued to work closely with components of DoD and veterans service organizations (VSOs) to provide military funeral honors at national cemeteries. While VA does not provide these honors, national cemeteries facilitate the provision of military funeral honors and provide logistical support. Veterans and their families have indicated the provision of military funeral honors for the deceased veteran is important to them.

VA continued to work with funeral homes and VSOs to find new ways to increase awareness of benefits and services. Funeral directors and VSO members participated in focus groups to identify what information they need and the best way to ensure they receive it.

Data Source and Validation

Percent Served by a Burial Option

Experience and recent historical data show that about 80 percent of those interred in national cemeteries resided within 75 miles of the cemetery at the time of death. From this experience, NCA considers eligible veterans to have reasonable access if a burial option (whether for casketed remains or cremated remains) is available within 75 miles of the veteran's place of residence. NCA determines the percent of veterans served by existing national and state veterans cemeteries within 75 miles of their residence by analyzing census data on the veteran population. Arlington National Cemetery, operated by the Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, operated by the Department of the Interior, are included in this analysis.

Since 2000, actual performance has been based on the VetPop2000 model developed by VA's Office of the Actuary. VetPop2000 is the authoritative VA estimate and projection of the number and characteristics of veterans. It was the first revision of official estimates and projections since 1993. The VetPop2000 methodology resulted in

significant changes in the nationwide estimate and projection of the demographic characteristics of the veteran population. These changes affected the individual county veteran populations from which NCA determines the percentage of veterans served. Projected openings of new national or state veterans cemeteries and changes in the status of existing cemeteries are also considered. (Multiple counts of the same veteran population are avoided in cases of service-area overlap.)

In 1999, the Office of the Inspector General performed an audit assessing the accuracy of data used to measure the percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence. Audit results showed NCA personnel generally made sound decisions and accurate calculations in determining the percent of veterans served by a burial option. Although inconsistencies in NCA's estimate of the percent of the veteran population served by a burial option were identified, they did not have a material impact, and no formal recommendations were made. VA has addressed these inconsistencies, and the adjustments are included in the data contained in this report.

Quality of Service Provided by National Cemeteries

From 1996 through 2000, the source of data used to measure the quality of service provided by national cemeteries was the NCA Visitor Comment Card. Since 2001, an annual nationwide mail survey, Survey of Satisfaction with National Cemeteries, has been NCA's primary source of customer satisfaction data. The survey collects data annually from family members and funeral directors who received recent services from a national cemetery. To ensure sensitivity to the grieving process, NCA allows a minimum of 3 months after an interment before including a respondent in the sample population. The measure for quality of service is the percent of respondents who agree or strongly agree that the quality of service received from cemetery staff is excellent.

VA headquarters staff oversees the data collection process and provides an annual report at the national level. MSN and cemetery level reports are provided for NCA management's use. The mail-out survey provides statistically valid performance information at the national and MSN levels and at the cemetery level for cemeteries having at least 400 interments per year.

Objective

Provide veterans and their families with timely and accurate symbolic expressions of remembrance.

Performance Goal

Baseline the percent of graves in national cemeteries marked within 60 days of interment.

Definition: *The measure for timeliness of marking graves in national cemeteries is the number of graves in national cemeteries for which a marker has been set at the grave, or the reverse inscription completed, within 60 days of the interment divided by the number of interments, expressed as a percentage.*

In 2002, VA began to measure the timeliness of marking graves in national cemeteries. Data were collected that showed a baseline of 49 percent of graves in national cemeteries were marked within 60 days of interment. The amount of time it takes to mark the grave after an interment is extremely important to veterans and their family members and, as a result, we are now tracking this as one of the Department's key performance measures. The headstone or marker is a lasting memorial that serves as a focal point not only for present-day survivors but also for future generations. In addition, it may bring a sense of closure to the grieving process to see the grave marked.

Means and Strategies

VA provides headstones and markers for the graves of eligible persons in national, state, other public, and private cemeteries. Delivery of this benefit is not dependent on interment in a national cemetery. In 2002, NCA provided over 360,000 headstones and markers for placement in national, state, other public, and private cemeteries.

NCA is reengineering business processes, such as ordering and setting headstones and markers, to improve performance. Monthly and fiscal year-to-date tracking reports on timeliness of marking graves can be accessed online by NCA field and headquarters employees. Increasing the visibility and access of this information further reinforces the importance of marking graves in a timely manner.

We will continue to improve accuracy and operational processes in order to reduce the number of inaccurate or damaged headstones and markers delivered to the gravesite. Headstones and markers must be replaced when either the Government or the contractor makes errors in the inscription, or if the headstone or marker is damaged during delivery or installation. When headstones and markers must be replaced, it further delays the final portion of the interment process.

NCA will also continue to improve operational efficiencies and reduce costs through its reverse inscription program. In this program, a second inscription is added *in situ* (i.e., at the gravesite) to the currently existing headstone following the death and interment of a subsequent family member. In 2002, NCA contracted for over 6,600 reverse inscriptions.

To the maximum extent possible, NCA will use modern information technology to automate its operational processes. Online ordering using NCA's Automated Monument Application System - Redesign (AMAS-R) and electronic transmission of headstone and marker orders to contractors increase the efficiency of the process. NCA is also increasing its efficiency by encouraging other federal and state veterans cemeteries to place their orders for headstones and markers directly into the AMAS-R system. Thirty-four other federal and state veterans cemeteries had the capability to order headstones and markers online in 2002.

Crosscutting Activities

NCA provides headstones and markers for national cemeteries administered by the Department of the Army, the Department of the Interior (DOI), and the American Battle Monuments Commission. Arlington National Cemetery, which is administered by the Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, which are administered by DOI, order headstones and markers directly through NCA's AMAS-R monument ordering system. In addition, NCA contracts for all niche inscriptions at Arlington National Cemetery.

NCA also provides headstones and markers to state veterans cemeteries. Equipment and training are provided to state veterans cemeteries to encourage them to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. NCA also extends its second inscription program to state veterans cemeteries. In order to participate, state cemeteries must use upright headstones and have the capability to submit requests electronically.

NCA administers the White House program for Presidential Memorial Certificates (PMCs). A PMC is an engraved paper certificate, bearing the President's signature, to honor the memory of honorably discharged deceased veterans. Eligible recipients include the deceased veteran's next of kin and loved ones. In 2002, VA provided nearly 290,000 PMCs.

External Factors

Headstones and markers are supplied by various contractors throughout the country, whose performance greatly affects the quality of service provided to veterans and their families. The timeliness of delivery of headstones and markers is dependent not only on the performance of the manufacturer but also on the performance of the contracted shipping agent. Extremes in weather, such as periods of excessive rain or snow, or extended periods of freezing temperatures that impact ground conditions, can also cause delays in the delivery and installation of headstones and markers.

Data Source and Validation

Data on workload and timeliness of marking graves are collected monthly through field station input to the Burial Operations Support System (BOSS) and AMAS-R. The measure for timeliness is the percent of graves in national cemeteries for which a marker has been set at the grave, or the reverse inscription completed, within 60 days of the interment. VA headquarters staff oversees the data collection process and provides monthly and fiscal year-to-date reports for NCA management's use at the national, MSN, and cemetery levels. NCA will continue to monitor the data collected for this new performance measure to validate its accuracy and integrity.

The number of headstones and markers provided includes markers ordered by the NCA Centralized Contracting Division. The total number of PMCs issued, which includes those issued to correct inaccuracies, is reported monthly. Headquarters staff reviews the data for general conformance with previous report periods, and any irregularities are validated through contact with the reporting station.

When headstones or markers are lost, damaged, or incorrectly inscribed, it is important to determine both the cause and the party responsible for the expense of a replacement in order to improve performance. NCA developed new codes for ordering replacement headstones or markers and published a users guide showing definitions for all codes, including the replacement reasons. Use of these new codes has enhanced the BOSS and AMAS-R databases by producing reliable and accurate data on replacement actions and providing management with an effective tool for improving the overall business process.